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EARLY DETECTION AND PREVENTION OF EMOTIONAL DISORDER--CONCEPTUALIZATIONS AND PROGRAMMING.

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CONCEPTS, ISSUES, AND RESEARCH RESULTS RELEVANT TO THE MENTAL HEALTH FIELDS ARE PRESENTED. THE DEMAND FOR SERVICES FAR EXCEEDS AVAILABLE RESOURCES. TYPICALLY, THE APPROACH TAKEN HAS BEEN PASSIVE-RECEPTIVE. PATHOLOGY HAS BEEN ARRESTED AND MODIFIED. IT HAS BECOME INCREASINGLY EVIDENT, HOWEVER, THAT THIS EMPHASIS ON PATHOLOGY AND CURE IS UNWISE. CONCERN SHOULD BE FOCUSED ON THE ORIGIN AND FLOW OF DISORDER. UNFORTUNATELY, PRIMARY PREVENTION WOULD INVOLVE A COMPLETE OVERHAUL AND REBUILDING OF SOCIETY. SECONDARY PREVENTION IS FEASIBLE. THROUGH EARLY DETECTION AND TREATMENT, THE DURATION AND IMPACT OF DISORDERS CAN BE CURTAILED. TERTIARY PREVENTION SEEKS TO KEEP IMPAIRMENT AT A MINIMUM. SECONDARY PREVENTION IS THE PREFERRED FOCUS, BUT EVEN THIS REQUIRES A CHANGE FROM ONE-TO-ONE CLINICAL SERVICES TO CONSULTATIVE, EDUCATION, SUPERVISORY, AND RESOURCE FUNCTIONS FOR PROFESSIONAL PERSONNEL. RESEARCH IN EARLY DETECTION AND SECONDARY PREVENTION IN THE SCHOOL SETTING IS SUMMARIZED. FINDINGS POINT TO FAIRLY RICH POTENTIALS FOR A PREVENTIVE APPROACH IN THE SCHOOLS. MOST PROGRAMS HAVE THE FOLLOWING FEATURES--A FOCUS ON EARLY SECONDARY PREVENTION, UTILIZATION OF SUBPROFESSIONALS, AND SERVICE, BY PROFESSIONALS, IN CONSULTATIVE AND RESOURCE CAPACITIES. THIS PAPER WAS PRESENTED AT THE ANNUAL MEETING OF THE AMERICAN PSYCHOLOGICAL ASSN., (75TH, WASHINGTON, D.C., SEPTEMBER 2, 1967). (SK)

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Early Detection and Prevention of Emotional Disorder: Conceptualizations and Programming[1]

by

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The objectives of this paper are twofold, and limited. The first is to articulate several primitive conceptualizations relevant to the mental health fields today. The second aim, if only by way of brief summary, is to review some of our principal research findings, within the framework of our guiding philosophy.

Increasingly, mental health professionals have come to realize the insufficiency of our network of helping operations (Cowen, 1967). For example, we now recognize that our best efforts have failed to result in noteworthy progress with entire classes of disorder; schizophrenia well illustrates this point. Technology (e.g., psychotherapy) that is fundamental to our current "bag of tricks" is of limited effectiveness clinically, and is certainly restricted in its scope (Schofield, 1964; Cowen and Zax, 1967). Profound biases exist in the availability of mental health services with respect to variables such as race, social class, geography and educational level (Samua, 1966). Unfortunately, these operate according to the rule of where help is most needed it is least available. Moreover, for vast segments of the population we have been grossly deficient in working out modes of delivery of services which are consonant with the life styles and social realities of potential recipients (Reiff, 1967; Riessman, 1967). Underlying the foregoing is the realization the demand for helping services, let alone need, substantially exceeds available resources; present extrapolations suggest that this gap is growing rather than narrowing (Albee, 1959, 1963, 1967; Nichols, 1963). The enormity of these problems dictates that careful scru-

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tiny be given to our prior guiding assumptions and practices (Cowen, Gardner and Zax, 1967).

Historically, "practice" in the mental health fields has focused on the goal of arrest and modification of pathology. The everyday operations of helping specialists typically begin when people experiencing emotional difficulties seek them out. Obstacles, whether economic, geographic or psychological are often sufficiently formidable so that the individual does not ask for help until discomfort is advanced and symptomatology well entrenched. At that time the helping specialist is seen as a knowledgeable expert who will prescribe (perhaps words rather than medicine) and cure, much as the physician does in treating flu. Professional practice has been supportive of this view. We have sought, through diagnosis, to understand the nature of psychic disorder and, through treatment, to modify it, largely within the framework of the one-to-one clinical interaction. Our stance toward mental health problems has been, passive-receptive--seeking to do the best "patch-work" possible in known instances of dysfunction.

Notwithstanding dramatic increases in facilities, resources, budgets and professional personnel in past decades, it would be difficult to argue that we have achieved proportional reduction in the number and seriousness of mental health problems. Rather, we have struggled desperately to tread water. Thus, the need for alternative conceptualizations about "cause and cure" in the mental health fields assumes paramount importance.

A critical shortcoming of society's efforts to cope with emotional perturbation resides in its historical emphasis on pathology and its cure, rather than on the origin and flow of disorder. Any comprehensive system of long-range planning in the mental health fields should accord central significance to issues of prevention. The implicit assumption of analogy between psychological and physical disorder has, doubtless, been a stultifying one. Whereas physical disorder implicates invasion by some type of pathogenic agent, psychological dysfunction more likely reflects complex, long-standing determinants

and processes and varied sources of influence, including important "others" in the person's life space, and key social institutions.

Our concerns need sharper focus in these latter directions. We must learn more and do more about building for psychological resources and for health, rather than simply counterpunching against pathology. Such an orientation underscores the need for examination of influential primary institutions in modern society and establishes the centrality of questions such as: How do primary institutions influence emotional and personality development? How are these impactful systems modified; and what is the relationship between institutional change and optimal psychological development? The long-range aim of such inquiry is to create conditions to reduce the flow of disorder.

Lately, "market value" of the term prevention has gone up considerably. This should not obscure the fact that it is an expansive, elusive concept covering a variety of objectives and functions. Primary prevention implies re-doing the very fabric of society. As such, it implicates skills and know-how far beyond the combined resources of the helping professionals, let alone psychology by itself. Secondary prevention, whether defined as early in the life history of the organism or early in the course of a given episode of disorder, seeks to curtail the duration and impact of disorder, through early detection and treatment. Tertiary prevention is aimed at entrenched, essentially irreversible, pathology; its purpose is to keep impairment minimal. It is questionable that this function is properly described as prevention. Our own preferred focus when using the term is on primary prevention and on ontogenetically early secondary prevention.

Much of our particular interest in "community mental health", these days a projectivist's bonanza, is justified in terms of prospective functions rather than geography. We stand to gain little through simple transplantation of Szondi plates or intensive therapy from clinics to courthouses.

schools, factories or prisons. To us, the real value of a shift from the consulting room to the community and its primary institutions lies in the opportunities for generating preventively-oriented programs, for constructive modification of social systems and for meaningful extension of the reach of our helping operations to the multitudes of heretofore unreached. Our needs for such expansion are more nearly geometric than arithmetic. That we already lack sufficient professional personnel in the mental health fields and that prospects for solutions along this dimension are, at best, dim (Albee, 1967) point up the importance of two further types of developments: (1) exploration of new ways for effective utilization of non-professionals, and (2) recasting a substantial portion of the role of the professional in directions elsewhere described (Cowen, 1967) as those of the "social engineer" and "mental health quarterback." This implies retrenchment on "one-to-one" clinical service activities in favor of consultative, educative, supervisory, and resource functions. To achieve these ends, there is need for change in conception and implementation of graduate training in the several helping professions.

Much of what has been said thus far is an introductory articulation, however primitive, of a conceptual credo. We now turn, at least briefly, to some of our supporting research efforts. The perceptive reader may soon detect substantial discontinuity between crystal-ball gazing and empirics. Largely, this reflects the issue of "point of address" of one's research efforts. In the armchair it is not difficult to be global and far-ranging, especially if one is at all tolerant of loose ends and islands of fuzziness. The issues thus identified are broad in scope and suggest a variety of approaches, at different levels, to diverse problems--far beyond the resources and know-how of any single group of professionals. The research to be summarized is considerably narrower than the prior theoretical speculations. Our chosen "point of address" is that of early detection and early secondary prevention of emotional disorder in the school setting. This choice reflects a blend of pre-

meditation and serendipity that defies precise itemization of ingredients. Some limited portions of our rationale, however, can be made less mystical.

One vital focus of a comprehensive, preventively-oriented approach to mental health problems, historically underplayed, is the young child and his environment. In this context, the family and the school represent primary institutions of major import. In particular, the school, both because of its accessibility and inevitably heavy and enduring impact upon all members of society in their formative years, represents a unique situation for program development and research. Opportunities for curriculum modification in keeping with learning and mental health principles, concerted efforts to create school environments which favor optimal psychological development, mental health related training for teachers and selected teachers early identification of emotional disturbance, and the development of interventive models designed to curtail the negative sequelae of such disturbance, as a representa an area of some potential.

Much of our effort in recent years has centered around the establishment and evaluation of experimental programs for the early detection and prevention of emotional disorder in very young school children. We have focused primarily on two broad problems: (1) assessment of the effectiveness of the experimental programs, and (2) development of techniques for early identification of ineffective functioning. Implicit in the second objective is a concern about the extent to which children, so identified, are differentiable from more effectively functioning peers with respect to a series of independent performance, achievement and behavioral measures.

Our programs for early detection and prevention have been described in detail in the literature (Cowen, Izzo, Miles, Telschow, Trost and Zax 1963; Zax, Cowen, Izzo, and Trost, 1964; Cowen, Zax, Izzo and Trost 1966;

Zax and Cowen, 1967) and will, therefore, be summarized only briefly here. Psychological evaluation of first-grade children, social work interviews with their mothers, classroom observation, and reports by teachers provided the materials for early detection of disorder. Based on an amalgam of such information children have been divided, for research purposes, into one of two groupings. The designation Red-Tag was used for those youngsters who, on the basis of all available evidence, had already manifested disorder ranging from moderate to severe, or in whom such pathology seemed incipient. In schools we have worked in thus far that figure has run about 35-40%. All other children were called Non-Red-Tag. This has been an arbitrary, fallible, clinical impression--internal to the research staff. It is neither made part of the child's record nor known to teachers or school administrators. In subsequent research (Beach, Cowen, Trost, Izzo, Laird, Zax, 1967) we have been able to identify, in greater detail, some of the determinants of the red-tag judgment, particularly those deriving from the social work interview which accounts for a goodly share of the rating variance. We have also taken steps to increase the sensitivity of the judgment by expanding it to a seven-point scale, with demonstrable reliability.

Our prevention program has gone through certain metamorphases over the years. Perhaps its most enduring component has been the utilization of professional staff as an educative, consultative and resource team. School personnel, especially teachers, are provided on-going opportunities to meet with Mental Health Clinical Services (MHCS) team members[2] to discuss problems relating to individual children, to classroom management, and to the role of being a teacher. Initially, lunch hours and after-school times were used for such consultation. More recently, however, recognizing the centrality of this function to our program, we have acquired the services of a substitute teacher to

free the classroom teacher for discussion and consultative conferences, during regular school hours. A consulting psychiatrist[3] has also functioned centrally on the project staff as a resource person and in individual and small group conferences with teachers and members of the MHCS staff. Other aspects of the preventive program include parent meetings, teacher meetings and, more recently, several specially designed interventive mechanisms utilizing non-professionals both on an "in-school" and "after-school" basis.

In order to assess the effectiveness of the program a battery of objective assessment procedures was utilized, including school record data (e.g., days absent, nurses' referrals, report-card grades, achievement-aptitude discrepancy scores, etc.), standard achievement tests (e.g., SRA Reading and Arithmetic) and personality and behavior measures (e.g., teacher ratings, peer ratings, and self-ratings). These indices, with some modification, have been applied twice. In each instance the target group consisted of third-grade youngsters who had been exposed to the program for three years. Two control schools, demographically comparable to the experimental school, provided a frame of reference for the evaluation.

Analysis of the data has been completed for both groups. Data from the second year are basically consistent with the earlier ones; indeed, in a number of instances they appear to be even stronger and more clear-cut. Looking at the findings for both year groups, we may conclude that: (1) there is a cluster of salutary consequences of the prevention program tapping adjustive, performance, achievement and sociometric measures in children exposed to it for three years; (2) children evidencing ineffective behavior in the first school years (Red-Tag) are, by the end of the third year: performing less adequately in school, showing greater signs of maladjustment on both objective tests and behavioral ratings, obtaining lower scores on standard achievement tests, being rated more negatively sociometrically, manifesting more physical

complaints in the school situation, all in comparison to their Non-Red-Tag peers (Cowen, et al., 1966).

We have undertaken follow-up studies of the alumni of our first prevention program, at seventh-grade level, four years after their exposure to the special program ended, in order to determine the stability or ephemerality of earlier findings. In this content, we recently reported (Rappaport, Zax, Izzo, Beach, Cowen, Laird and Trost, 1967) evidence indicating that the early-diagnosed "Red-Tag" child, left untreated, continued to show evidence of poorer development throughout his entire elementary school career.

Our findings, to date, point to some fairly rich potentials for a preventive approach in the schools. The high incidence of early pathology and its already serious consequences within the first three school years suggest that there is much room here for intensive exploration of secondary preventive measures. This is an area in which we have only recently become involved.[4] The problem is this: Granted that "high-risk" Red-Tag youngster can be identified and that, left untreated, they do very poorly in the first three school years, what if anything can be done to halt or reverse the seemingly inevitable downward spiral? Considerable effort in the past several years has been invested in the design, implementation and field-testing of several interventive programs, guided by the conceptual orientation we have described, and built on the findings of our earlier research. These programs have in common: a focus on early secondary prevention, heavy utilization of non-professionals, and use of the mental health professional in a consultative and resource capacity.

One of our "programs-in-action" has recruited and trained middle-aged housewifes for roles as mental-health-aides in the schools (Zax, Cowen, Izzo, Madonia, Morenda and Trost, 1966). Such women, though they have been

incorporated in a variety of volunteer programs in the past, have tended to be used for relatively trivial jobs such as chauffeuring, distributing books, cleaning blackboards, etc., when in fact they have much to offer in interpersonal relationships and as a resource in the mental health helping enterprise. We have recruited and provided focused, time-limited training, including both didactic-discussion meetings on mental health relevant issues and guided experience in clinical observation, for a group of six (not especially highly educated) housewives. This training sought to equip them to function as mental health aides in the school. Several models for the functioning of the housewife aide have already been explored, each of which presumes at least half-time involvement to assure continuity and relatively stable relationships with the child. One such model "stations" the housewife directly in the classroom; the second has her in the school building, combining classroom observations and "on-call" service with children. The aide is oriented toward the educational and emotional needs of the disturbed child who, in many instances, cannot, receive special attention from the teacher who is charged with the progress of her <u>entire</u> class. Through such efforts the child with withdrawal tendencies may be encouraged to come out of his shell and the over-active child who needs attention may get this <u>plus</u> intelligent guidance toward useful pursuits before either type becomes rigidified in a pathological pattern.

A second program (Cowen, Zax, Laird, 1966) utilizes undergraduate education majors as companions in after-school activity programs with children referred by their teachers because of emotional difficulties--particularly acting-out problems, problems of shyness, timidity and withdrawal and those of educational underachievement. This program also involves fourth-year clinical graduate students, hopefully providing for them a meaningful experience in the community and the schools, and a taste of functioning in a

consultative-resource capacity. Our pattern of operation runs roughly as follows: Each graduate student works with a group of six undergraduate volunteers. Each volunteer is assigned specifically to an individual child or a pair of children. Twice a week volunteers and graduate student leaders go to the schools. Activities with the children take place between 3:30 and 4:45 P.M. Then the entire group returns to campus for a post-mortem discussion between 5 and 6 P.M. These discussions range across topics such as trying to understand the child's behavior, considering the efficacy of varying types of actions and interventions, and trying to deal with the volunteer's concerns about his own role and function (Zax and Cowen, 1967). It seems that this program may have potential not only for its effects on young children, but also by providing prospective teachers with a mental-health oriented practicum experience--a long-range step in the direction of primary prevention.

The third group of non-professionals that we have trained to work as mental health aides with young children in the schools consists of retired people. Here training and function, though less intensive, was guided by our experience with housewives. The results of this project (Cowen, Leibowitz and Leibowitz, 1968) have been encouraging. Independent objective data obtained from teachers and aides indicated that referred children profited significantly from their experience. Moreover, participation in the program was a gratifying experience for the retirees as well. This latter fact may well illustrate Riessman's (1965) helper-therapy principle (i.e., the therapeutic value deriving to oneself from the process of being genuinely helpful to another human being).

While the school, as a "heavy-impact" primary institution is necessarily a <u>basic</u> sphere of operation for preventively oriented mental health

programs, it is not the only one. Nor are the specific manpower, recruitment, and training models utilized in that setting likely to be equally effective with all other groups and settings. Based on these assumptions we have also undertaken a highly exploratory program, in cooperation with a local settlement house, involving recruitment and training of indigenous Negro youth (ages 15-18) from Rochester's "inner-city" areas, to work in a one-to-one counselor-type relationship with very young neighborhood children refereed for emotional problems by agency staff. Once again advanced clinical students are actively involved in a training-resource-supervisory capacity. As in our program for retired couple, and in other programs for disadvantaged urban groups (Riessman, 1967; Klein, 1967), the potential operation of the helper-therapy phenomenon may again be noted.

The foregoing examples are limited to situations in which we have had concrete experience. They reflect, however, a key underlying principle which should be underscored because of its potential applicability to a variety of community mental health settings.

We know that the need for professional help already far outstrips available resources. Best estimates indicate that this disparity will increase over time. Hence we must develop and exploit less saturated, mental-health training situations in which considerably larger numbers of individuals are provided with appropriate background and experience. Such individuals would form a corps of field workers which would geometrically expand the range of mental health relevant contacts with those in the community requiring help. As this model is developed and applied, there will be need for the mental health professional to exercize the vital educative, supervisory and resource functions. Doubtless, this will entail parallel encroachment upon his traditional functions and will require modification and extension of graduate training programs and practicum

experiences for helping professionals.

In closing, we offer a view, derived from our thinking and research findings, of an important direction for movement by the mental health helping professions: Fundamental marker characteristics of the professional mental health specialist several decades hence should include a clear orientation toward early detection of emotional pathology or incipient pathology, and toward preventive interventions (both primary and secondary) designed to forestall the occurrence of disorder. A substantial portion of our focus should be directed to the very young child. This is in contrast to past dominant emphases on severe symptomatology, well entrenched in older individuals, and on the one-to-one diagnostic and treatment model. The professional specialist in implementing this new, preventive orientation, will inevitably act as an educator, consultant and resource person for a new corps of non-professional specialists which must be created if we are to deal meaningfully with serious present-day manpower shortages. Graduate training in the helping professions must emphasize consultative and preventive orientations affecting many, as well as individual diagnosis and treatment of the few. Only by effectuating change of this general nature, does it seem possible that a mental health "helping" structure capable of meeting existing, very real, social needs can come about.

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Footnotes

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